STATE OF CONNECTICUT

BOARD OF EXAMINERS FOR NURSING

Department of Public Health

vs.

Debra Tartaglia-Grenfell, RN, Lic. No. E49535
Respondent

Petition No. 990316-010-019

MEMORANDUM OF DECISION

Procedural Background

The Board of Examiners for Nursing (hereinafter "the Board") was presented by the Department of Public Health (hereinafter "the Department") with a Statement of Charges and Motion for Summary Suspension dated March 26, 1999. The Statement of Charges alleged violations of certain provisions of Chapter 378 of the General Statutes of Connecticut by Debra Tartaglia-Grenfell, R.N. (hereinafter "respondent") which would subject the respondent's Registered Nurse license to disciplinary action pursuant to the General Statutes of Connecticut.

Based on the allegations in the Statement of Charges and accompanying affidavits and reports, the Board found that the respondent's continued nursing practice presented a clear and immediate danger to public health and safety. On April 7, 1999, the Board ordered, pursuant to its authority under §4-182(c) and §19a-17(c) of the General Statutes of Connecticut, that the respondent's Registered Nurse license be summarily suspended pending a final determination by the Board of the allegations contained in the Statement of Charges. Dept. Exh. 1.

The Board issued a Notice of Hearing dated April 8, 1999, scheduling a hearing for April 21, 1999.

Before the Board had an opportunity to hold the first hearing, the respondent made three separate requests for continuances. All of these requests were granted. The hearings took place on November 17, 1999, March 1, 2000, March 29, 2000, July 19, 2000 and September 20, 2000.

Respondent was present during the following hearing dates: November 17, 1999, March 1, 2000, March 29, 2000, and July 19, 2000, and was represented by counsel on every hearing date.

Respondent submitted a written Answer to the Statement of Charges. Respondent Exh. A.

On November 17, 1999, the Department made an oral amendment to paragraph nine of the second count of the Statement of Charges. Transcript, November 17, 1999, pp. 6-7.

On February 18, 2000, the respondent filed a Motion to Dismiss. Respondent Exh. E. On February 28, 2000, the Department filed an objection to respondent's Motion to Dismiss. Dept. Exh.

12; Transcript, March 1, 2000, p. 41. On March 1, 2000, the Board heard oral arguments on the Motion to Dismiss and denied the motion. Transcript, March 1, 2000, pp. 11-33.

On March 1, 2000, the Department filed a written and oral Motion to Amend the Statement of Charges. Dept. Exh. 11. The Board heard arguments and granted the motion. Transcript, March 1, 2000, pp. 37-41. The Department filed a Motion to Amend the Amended Statement of Charges. Board Exh. 2. The Board granted this motion. Board Exh. 4.

Each member of the Board involved in this decision attests that he/she was present at the hearing or has reviewed the record, and that this decision is based entirely on the record, the law, and the Board's specialized professional knowledge in evaluating the evidence.

Allegations

The FIRST COUNT, PARAGRAPH 3 of the Second Amended Statement of Charges alleges that, on several occasions, while working as a Registered Nurse at Yale-New Haven Children's Hospital, respondent:

a. diverted Morphine, Meperidine, and/or Percocet;
b. failed to completely, properly and/or accurately document medical or hospital records; and/or,
c. falsified one or more Controlled Substance Receipt Records. Board Exh. 2.

The FIRST COUNT, PARAGRAPH 4 of the Second Amended Statement of Charges alleges that, at various times in 1998 and 1999, respondent abused or utilized to excess Vicodin, Tylenol #3, Chloral Hydrate, Klonopin, Pentobarbital, Valium, Morphine, Meperidine, and/or Percocet. Board Exh. 2.

The FIRST COUNT, PARAGRAPH 5 of the Second Amended Statement of Charges alleges that respondent's abuse of the aforementioned drugs does, and/or may, affect her practice as a Registered Nurse. Board Exh. 2.

The SECOND COUNT, PARAGRAPH 3 of the Second Amended Statement of Charges alleges that, while in the course of her duties as a nurse at Yale-New Haven Children's Hospital, respondent violated the applicable standard of care for her patients in one or more the following ways:

a. On or about December 27, 1998, she administered PG gel without a doctor's order and in contravention of hospital policy that a doctor must administer the medication. In addition, she failed to chart the administration of the PG gel or to communicate to the nursing shift that she had administered it.[1]

[1] During the hearing held on July 19, 2000, the parties stipulated that the word Misoprostol, stated in paragraph three of the Second Count of the Second Amended Statement of Charges, should be replaced with PG gel (prostaglandin gel). Transcript, July 19, 2000, pp. 121-123.

b. On or about January 27, 1999, she administered Morphine to a patient without performing an assessment of the patient's need for Morphine and without charting any increase in the patient's pain. In addition, she administered the Morphine by an improper method and without a doctor's order for it.

c. On or about February 15, 1999, she gave a tablet of Demerol to a patient who had no order for narcotics and who had a known history of drug use and, later, she gave an injection of Demerol to the same patient upon her discharge. She did not perform or chart a patient assessment which justified the need for the Demerol. Hospital policy and training prohibits the nurses from giving discharged patients medications for home use.

d. On or about February 11, 1999, she began a 300 mg PCA dose of Meperidine at 1146 and wasted the entire 300 mg at 1414 without noting that the patient had drawn none of the medication and without instructing the patient how to use the pump.

e. On or about February 17, 1999, she changed a patient's medication from Ibuprofen to Meperidine without charting a change in the patient's pain and without performing an assessment of the patient, and then gave the patient Demerol 100 mg to take home without any order for such medication.

Respondent filed an Answer to the Statement of Charges. Respondent Exh. A.

Findings of Fact

Based on the testimony given and the exhibits offered into evidence, the Board makes the following findings of fact:

1. Respondent is, and has been at all times referenced in the Statement of Charges, the holder of Registered Nurse license number E49535. Dept. Exh. 11; Respondent Exh. A.

2. At all relevant times, respondent was employed as a Registered Nurse at Yale-New Haven Children's Hospital. Dept. Exh. 1.

3. On March 6, 1996, the Board issued a Memorandum of Decision in Petition number 950411-010-041 (hereinafter "the March 6, 1996 Order") that placed respondent's Registered Nurse license on probation for a period of four years. Such disciplinary action was based upon respondent's admission of abuse of alcohol and/or Percodan. Dept. Exh. 2; Transcript, November 17, 1999, p. 13.

4. Yale-New Haven Hospital utilizes a computerized automated medication distribution system known as "Pyxis." Facilities use the Pyxis machines for dispensing medications and controlled substances. Transcript, March 1, 2000, pp. 82-83.

5. The Yale-New Haven Hospital Pyxis audit reports indicate that the respondent's withdrawals of Percocet for the months of November 1998 to February of 1999 were two to three times higher than those of other nurses who worked twice as many hours as the respondent. Additionally, respondent worked with the antepartum population which uses fewer narcotics than the postpartum population. Dept. Exh. 14; Transcript March 1, 2000, pp. 61-70.

6. In order to access the Pyxis machine, a doctor must first issue an order for the medication. A nurse can override the Pyxis system to obtain medication that is inconsistent with the doctor's order. An override is typically done when there is only a verbal order in an emergency

situation. After the override, the nurse is required to document in the medical record that she or he has given the medication to the patient, that she has assessed the patient, and the effect of the medication. The physician is required to enter a written order in the medical record. Transcript, November 17, 1999, pp. 61-62.

7. When a nurse does an override, the medication that is withdrawn pursuant to the override is typically administered quickly to the patient. In the event that the patient no longer needs the withdrawn medication, the nurse must return the medication to the Pyxis machine, or discard it and chart it in the Pyxis machine as wasted. Transcript, November 17, 1999, p. 82.

8. At various times in 1998 and 1999, respondent tested positive for, and abused or utilized to excess, Vicodin, Percocet, Tylenol #3, Chloral Hydrate, Klonopin, Pentobarbitol, and/or Valium. Dept. Exh. 2.

9. In the course of her performing her duties as a nurse at Yale-New Haven Children's Hospital, respondent violated the applicable standards of care for her patients in one or more of the following ways:

    a. On or about December 27, 1998, respondent administered PG gel without a doctor's order and in contravention of hospital policy that a doctor must administer the medication. In addition, she failed to chart the administration of the PG gel or to communicate to the next nursing shift that she had administered it. Dept. Exh. 19; Transcript, March 1, 2000, pp. 72-76, Transcript, March 29, 2000, p. 13.

    b. On or about January 27, 1999, respondent administered 4 mg of Morphine IV to a patient without performing an assessment of the patient's need for Morphine and without charting any increase in the patient's pain. In addition, she administered the Morphine by an improper method and without a doctor's order. Dept. Exh. 5, and 16; Transcript, March 1, 2000, pp. 83-98; Transcript, March 29, 2000, pp. 140-143, 151-57, 186-188, 277; Transcript, July 19, 2000, pp. 48-49, 145-147, 187-189.

    c. On or about February 15, 1999, respondent gave an injection of Demerol upon discharge of a patient with a known history of street drug use who did not have an order for narcotics. She did not perform or chart a patient assessment which justified the need for the Demerol. Hospital policy and training prohibits the nurses from giving discharged patients medications for home use. Additionally, it is below the standard of care to give this level of analgesics upon discharge. Dept. Exh. 6, 20; Transcript, March 29, 2000, pp. 123-124, 195-197, and 207-213; Transcript, July 19, 2000, pp. 54-74.

    d. On or before February 11, 1999, respondent began a 300 mg PCA dose of Meperidine at 1146 hours and wasted the entire 300 mg at 1414 hours without noting that the patient had drawn none of the medication, with charted assessment or follow up, and without instructing the patient how to use the pump. Dept. Exh. 7; Transcript, July 19, 2000, pp. 149-154.

    e. On or about February 17, 1999, respondent changed a patient's medication from Ibuprofen to Meperidine without charting a change in the patient's pain and without performing an assessment of the patient, and then gave the patient Demerol 100 mg to be taken orally without any order for such medication. Dept. Exh. 8, 20; Transcript, July 19, 2000, pp. 65-71.

Conclusions of Law and Discussion

In consideration of the above Findings of Fact, the following conclusions are rendered:

Debra Tartaglia-Grenfell held a valid Registered Nurse license in the State of Connecticut at all times referenced in the Statement of Charges.

The Notice of Hearing and Statement of Charges provided sufficient legal notice as mandated by the General Statutes of Connecticut §4-177(a) and (b), and §4-182(c). The hearings were held in accordance with Chapters 54 and 368a of the General Statutes of Connecticut as well as §19a-9-1 through §19a-9-29 of the Regulations of Connecticut State Agencies.

The Notice of Hearing, Statement of Charges, and the hearing process provided the respondent with the opportunity to demonstrate compliance with all lawful requirements for the retention of her license as required by the General Statutes of Connecticut §4-182(c).

The Department bears the burden of proof by a preponderance of the evidence in this matter.

Based on its review of medical records, automated medication distribution system records and the testimony presented, the Board finds by a preponderance of evidence that the respondent, while working as a registered nurse at Yale-New Haven Hospital from November 1998 to February 1999, diverted from hospital stock the controlled substances Morphine, Meperidine, and Percocet. The Board further finds that respondent accomplished the diversion of the controlled substances by failing to completely, properly, and accurately document medical or hospital records and by falsifying one or more, Controlled Substance Receipt Records.

Respondent's explanation for the overrides and wastes is not credible. There is insufficient credible evidence to explain or justify the overrides. Rather, the evidence supports the conclusion that the respondent's actions were undertaken for the purpose of diverting the controlled substances.

Similarly, although the documentation indicates that the overrides were often wasted, based upon the totality of circumstances, respondent's testimony that she wasted the overrides was not credible.

Additionally, the Board finds that respondent failed to comply with the standard of care for registered nurses in that administering a PG gel is not a nursing function. A medical doctor must both order and administer PG gels. In another instance, the respondent failed to comply with the standard of care in that she should not have sent a patient home after receiving 100 mg of Demerol. Thus, respondent's poor nursing judgement and ability jeopardized patients' safety.

The General Statutes of Connecticut §20-99 provides in relevant part:

> (a) The Board of Examiners for Nursing shall have jurisdiction to hear all charges of conduct which fails to conform to the accepted standards of the nursing profession brought against persons licensed to practice nursing. After holding a hearing . . . said board, if it finds such person to be guilty, may revoke or suspend his or her license or take any of the actions set forth in section 19a-17 . . . (b) Conduct which fails to conform to the accepted standards of the nursing profession includes, but is not limited to, the following . . . (2) illegal conduct, incompetence or negligence in performing usual nursing functions . . . (5) abuse or excessive use of drugs, including alcohol, narcotics or chemicals . . . (6) fraud or material deception in the course of professional services or activities . . . .

Based on its findings, the Board concludes that respondent's conduct as alleged in the First and Second Counts of the Second Amended Statement of Charges is proven by a preponderance of the evidence presented. The Board further concludes that said conduct constitutes violations of the General Statutes of Connecticut §20-99(b), (2), (5) and (6). Therefore, respondent's Registered Nurse license is subject to disciplinary action pursuant to §19a-17 of the General Statutes of Connecticut.

Order

Pursuant to its authority under §19a-17 and §20-99 of the General Statutes of Connecticut, the Board of Examiners for Nursing hereby orders the following:

That for the First Count of the Second Amended Statement of Charges, the respondent's Registered Nurse license, number E49535, is revoked effective the date this Memorandum of Decision is signed by the Board of Examiners for Nursing.

That for the Second Count of the Second Amended Statement of Charges, the respondent's Registered Nurse license, number E49535, is revoked effective the date this Memorandum of Decision is signed by the Board of Examiners for Nursing.

The Board of Examiners for Nursing hereby informs respondent, Debra Tartaglia-Grenfell, and the Department of Public Health of the State of Connecticut of this decision.

Dated at Wethersfield, Connecticut this 3rd day of January, 2001.

BOARD OF EXAMINERS FOR NURSING

By _____